Supreme Court, U.S.
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No. 99-1363

In The

Supreme Court of the United States

JANET CARR,

Petitioner,

v.

THE GATES HEALTH CARE PLAN,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION

BRIAN J. SPANO
Counsel of Record
ROTHGERBER JOHNSON & LYONS LLP
1200 Seventeenth Street, Suite 3000
Denver, Colorado 80202
Telephone: (303) 623-9000

GARY NELSON
HEYL, ROYSTER, VOELKER & ALLEN
Suite 600, Bank One Building
124 S.W. Adams Street
Peoria, Illinois 61602
Telephone: (309) 676-0400

Attorneys for Respondent

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

1 Opp

QUESTION PRESENTED

Respondent disagrees with the Questions Presented by the Petitioner. Respondent presents the proper Question Presented, based upon Petitioner's Petition for a Writ of Certiorari, as follows:

Applying the arbitrary and capricious standard of review under ERISA, did the Seventh Circuit Court of Appeals correctly affirm the District Court's grant of summary judgment in favor of the Respondent on the grounds that the determination to deny benefits to Petitioner was not "downright unreasonable?"

LIST OF PARTIES TO THE PROCEEDING

Respondent The Gates Health Care Plan is sponsored by The Gates Corporation. The Gates Corporation is a wholly owned subsidiary of Tomkins US Holdings S.a.r.l., which is owned by Tomkins plc. There are no publicly held companies owning 10% or more of the stock of Respondent's sponsor, The Gates Corporation.

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STATEMENT OF JURISDICTION

The order and opinion of the Seventh Circuit Court of Appeals affirming the judgment of the United States District Court for the Central District of Illinois was entered on October 21, 1999. *Carr v. The Gates Health Care Plan,* 195 F.3d 292 (7th Cir. 1999). The Seventh Circuit Court of Appeals denied a Petition for Rehearing and Suggestion for Rehearing En Banc on November 17, 1999.

Petitioner's Petition for a Writ of Certiorari was docketed on February 15, 2000. Respondent acknowledges that if the case below otherwise presented a proper case for certiorari, jurisdiction would be proper under 29 U.S.C. § 1132(a)(1)(B), but Respondent denies that Petitioner presents a proper case for certiorari.

STATEMENT OF THE CASE

Petitioner's Statement of the Case contained in her Petition for a Writ of Certiorari fails to set forth several relevant facts in this case. In this action, Petitioner asserted a single claim for relief under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), for benefits allegedly due as a result of medical treatment received by her for complications arising from prior gastric bypass surgeries. During the relevant time period, Petitioner was a beneficiary under The Gates Health Care Plan ("Plan"), which is an employee welfare benefit plan governed by the provisions of ERISA.

The Plan is sponsored by The Gates Corporation, and provides medical benefits, subject to certain limitations and exclusions, to eligible employees of The Gates Corporation and their dependents. Under the Plan, the Health Care Benefits Review Committee ("Committee") is authorized, in its sole discretion, to interpret the Plan, construe disputed or ambiguous terms, decide all questions of fact that may arise under the Plan, and determine the right of any member to a benefit under the Plan. Pursuant to the terms of the Plan, the Committee's good faith interpretations and decisions are conclusive and binding on all parties.

At all relevant times, the Plan contained provisions which excluded coverage for "any services performed in connection with the . . . reduction . . . or change in appearance of a portion of the body" ("cosmetic exclusion"), and "gastric stapling or diversion for weight loss" ("gastric exclusion"). In addition to these Plan exclusions, Petitioner was advised by Respondent, in writing, in August 1992, three years before the medical treatment at issue in this action, that any future surgeries related to her gastric bypass procedures would not be covered by the Plan.

From June-December 1995, Petitioner received medical care for complications arising from prior elective gastric bypass procedures. After Petitioner demanded that Respondent pay for the medical expenses related to her treatment for complications of her prior gastric bypass procedures, the Committee met on several occasions to review and consider her claim. The Committee gathered and reviewed Petitioner's medical records, and additional information submitted by Petitioner's counsel and

her treating physician. The Committee retained an independent physician to assist it in evaluating Petitioner's claim for benefits. Ultimately, the Committee determined that the benefits requested by Petitioner were excluded from coverage under the Plan because Petitioner's medical treatment was directly related to her prior gastric bypass procedures. On July 25, 1997, the Committee sent a detailed 10-page letter to Petitioner setting forth the reasons for its determination that the Plan did not provide coverage for the benefits claimed.

Following the commencement of this action, Petitioner and Respondent filed cross-motions for summary judgment. Respondent asserted that it was entitled to summary judgment on the grounds that, under the arbitrary and capricious standard of review, Respondent's decision to deny Petitioner's claim for benefits should be upheld. In its Motion, Respondent relied upon the cosmetic exclusion and gastric exclusion as the principal grounds for denial of Petitioner's claim for benefits. Significantly, Petitioner did not contest the propriety of Respondent's reliance upon the cosmetic exclusion as a basis for denial of Petitioner's claim, but argued the application of the exclusion to the facts of the case.

On January 11, 1999, the United States District Court for the Central District of Illinois entered its Order denying Petitioner's Motion for Summary Judgment and granting Respondent's Motion for Summary Judgment. *See Order of the United States District Court for the Central District of Illinois, pp. 14(a)-31(a), attached to Petitioner's Petition for a Writ of Certiorari.* The District Court upheld Respondent's reliance upon the cosmetic exclusion and gastric exclusion in denying Petitioner's claim for benefits.

Petitioner appealed the adverse judgment to the Seventh Circuit Court of Appeals. Again, at no time during the appeal did Petitioner challenge the authority of Respondent to rely upon the cosmetic exclusion. The cosmetic exclusion was discussed, in detail, by the Seventh Circuit Court of Appeals in its opinion affirming the summary judgment in favor of Respondent. *See Opinion of the United States Court of Appeals for the Seventh Circuit, pp. 1(a)-13(a), attached to Petitioner's Petition for a Writ of Certiorari.*

SUMMARY OF ARGUMENT

Petitioner improperly seeks to persuade this Court to address issues set forth in her Petition for a Writ of Certiorari that were not raised in the proceedings before either the United States District Court for the Central District of Illinois or the Seventh Circuit Court of Appeals. Petitioner asserts that the central question presented to this Court is whether the Respondent may "add a new theory for denial of benefits, for the first time, after lawsuit has been commenced." *See Petitioner's Petition, Questions Presented.* Petitioner argues that Respondent should not be permitted to rely upon the cosmetic exclusion found in the Plan as a basis for denial of Petitioner's claim. This is the first time in this case that Petitioner has raised this issue as an alleged basis for overturning Respondent's denial of benefits to Petitioner.

The law is well-settled that Petitioner's failure to raise this issue in the proceedings below waives Petitioner's right to assert it for the first time before this

Court. At no time during the proceedings below did Petitioner ever challenge the propriety of Respondent's reliance upon any of the terms of The Gates Health Care Plan, including the cosmetic exclusion, in denying benefits to Petitioner. Instead, Petitioner argued the application or interpretation of the Plan exclusions relative to the facts of the case. Petitioner has waived her right to assert the first Question Presented in her Petition for a Writ of Certiorari.

In addition, as the United States District Court for the Central District of Illinois and the Seventh Circuit Court of Appeals have determined, summary judgment in favor of Respondent and against Petitioner was appropriate because, under the arbitrary and capricious standard of review, Respondent's denial of Petitioner's claim for benefits was not "downright unreasonable." Petitioner does not challenge the fact that she was afforded a full and fair opportunity to present her claim for benefits. The Respondent afforded Petitioner exemplary process in connection with its review of her claim, gathered Petitioner's medical information, received and considered the arguments and opinions of her treating physician and legal counsel, and was advised by an outside medical specialist. Respondent's decision that the Plan terms precluded coverage for Petitioner's claim for benefits reflected an informed judgment that was supported by sound rationale.

ARGUMENT

I. Petitioner Impermissibly Seeks To Raise New Issues In Her Petition For A Writ of Certiorari Which Have Been Waived Because Petitioner Failed To Present Them To The Courts Below.

In her Petition for a Writ of Certiorari, Petitioner impermissibly seeks to raise entirely new issues that were not raised in any of the proceedings below. For the first time, Petitioner now seeks to challenge the propriety of Respondent's reliance upon the cosmetic exclusion contained in the Plan. This argument was not raised in any of the proceedings below and has, therefore, been waived by Petitioner.

It is well-established that issues not raised before a lower court are deemed waived on appeal. *See, e.g., Town of Hallie v. City of Eau Claire,* 471 U.S. 34, 41, n.5, 105 S. Ct. 1713, 85 L. Ed. 2d 24 (1985); *Hormel v. Helvering,* 312 U.S. 552, 556, 61 S. Ct. 719, 85 L. Ed. 1037 (1941); *Bell v. Purdue University,* 975 F.2d 422 (7th Cir. 1992). Moreover, Petitioner's failure to contest Respondent's reliance upon a Plan term in connection with the cross-motions for summary judgment filed in the United States District Court for the Central District of Illinois waives Petitioner's right to raise this issue now. *See Liberles v. County of Cook,* 709 F.2d 1122, 1126-27 (7th Cir. 1983).

Significantly, Petitioner had every opportunity at the district court level to challenge the grounds upon which Respondent relied in seeking summary judgment. The law is well-settled that it was incumbent upon Petitioner to request a continuance to seek additional discovery pursuant to F.R.C.P. 56(f) if Petitioner believed that such

discovery was necessary to oppose Respondent's Motion for Summary Judgment. *See, e.g., Wallace v. Tilley*, 41 F.3d 296, 303 (7th Cir. 1994). To the extent that Petitioner needed additional time to conduct discovery in preparation of a response to Respondent's Motion for Summary Judgment, Petitioner was required to file an affidavit to that effect and seek relief pursuant to F.R.C.P. 56(f). Petitioner failed to do so, and cannot now raise issues which could and should have been resolved in the proceedings below. *See Chicago Florsheim Shoe Store Co. v. Cluett, Peabody & Co.*, 826 F.2d 725, 727 (7th Cir. 1987) (where plaintiff failed to seek relief under F.R.C.P. 56(f), appellate court cannot conclude that it was abuse of discretion to rule on summary judgment); *Hessel v. O'Hearn*, 977 F.2d 299, 305 (7th Cir. 1992) (where plaintiff failed to move for F.R.C.P. 56(f) continuance before lower court, raising the issue on appeal was "too late").

In her Petition for a Writ of Certiorari, Petitioner ignores the fact that she had a full and fair opportunity to litigate the merits of Respondent's interpretation of and reliance upon the terms of the Plan. In the proceedings below, Petitioner argued that Respondent's interpretation of the Plan terms was erroneous, and that the cosmetic exclusion and gastric exclusion did not preclude coverage for the benefits claimed by Petitioner. These arguments required the application of well-established law to the undisputed, albeit unique, facts of the case. Petitioner did not raise, and therefore, has waived her right to now challenge the propriety of Respondent's reliance upon the cosmetic exclusion as a basis for denial of Petitioner's claim for benefits. In addition, Petitioner ignores the fact that, in the Seventh Circuit, the omission from a final

denial letter of a basis for denial of a claim does not constitute a waiver of the terms of the Plan. *See Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d 895, 901 (7th Cir. 1993). Accordingly, Petitioner's argument is without merit and she cannot now seek to argue issues which were not properly raised in the proceedings below.

II. Summary Judgment In Favor Of Respondent Was Properly Entered By The District Court And Affirmed By The Court Of Appeals.

The United States District Court for the Central District of Illinois and the Seventh Circuit Court of Appeals appropriately reviewed Respondent's denial of Petitioner's claim for benefits under the arbitrary and capricious standard of review, and upheld Respondent's determination to deny benefits to Petitioner. It is undisputed in this case that Petitioner sought benefits for treatment directly related to her prior elective gastric bypass procedures. It is also undisputed that Petitioner was advised by Respondent in a letter, dated August 10, 1992, three years prior to the treatment at issue in this action, that any future surgery relating to her prior gastric bypass surgeries would not be covered. Based on a thorough analysis of Petitioner's medical records and other information, and the advice of an independent physician, Respondent appropriately determined that the benefits claimed by Petitioner were excluded by the terms of the Plan.

Petitioner did not contest the application of the arbitrary and capricious standard of review to the Respondent's decision to deny Petitioner's claim for benefits.

Under the arbitrary and capricious standard of review, a denial of benefits cannot be set aside if the denial was based upon a reasonable interpretation of the plan documents. *See, e.g., Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998), *cert. denied*, 119 S. Ct. 372, 142 L. Ed. 2d 307 (1998). Moreover, if a plan administrator makes an informed judgment and articulates an explanation for it that is satisfactory in light of the relevant facts, then the administrator's decision is final. *Loyola University of Chicago v. Humana Ins. Co.*, 996 F.2d at 989. Under the arbitrary and capricious standard, it is not the function of a reviewing court to decide whether it would reach the same conclusion as the Plan or even rely on the same authority. *Cvelbar v. CBI Illinois, Inc.*, 106 F.3d 1368, 1377 (7th Cir. 1997), *cert. denied*, 118 S. Ct. 56, 139 L. Ed. 2d 20 (1997), *abrogated on other grounds, International Union of Operating Engineers v. Rabine*, 161 F.3d 427 (7th Cir. 1998). Instead, under the standard articulated by the Seventh Circuit Court of Appeals, a reviewing court must uphold a denial of benefits unless the decision was "downright unreasonable." *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d at 1021.

Under the arbitrary and capricious standard of review, Respondent's determination to deny benefits to Petitioner was appropriate in light of the terms of the gastric exclusion and cosmetic exclusion. The Committee made an informed judgment and articulated a rational explanation for its decision. The Committee gathered and analyzed all relevant information, evaluated and addressed Petitioner's arguments and concerns, reviewed and evaluated the arguments and opinions of her treating

physician and counsel, and was advised by an outside medical consultant. The Committee adopted a reasonable interpretation of the Plan, and reached a judgment that was informed and supported by sound rationale. The determination by Respondent to deny Petitioner's claim for benefits was not "downright unreasonable," and was appropriately upheld by the United States District Court for the Central District of Illinois and the United States Court of Appeals for the Seventh Circuit.

CONCLUSION

This case does not present any "important question of federal law" which must be resolved by this Court. Nor does this case involve any federal constitutional issue or seek to resolve a division of opinion between any of the circuit courts of appeals. The principles of law applicable to a review of benefits under ERISA are well-settled, and were applied appropriately by the courts below in upholding Respondent's denial of Petitioner's claim for benefits. Moreover, Petitioner has waived her right to challenge in this Court the propriety of Respondent's reliance upon the cosmetic exclusion as one of the bases for denial of Petitioner's claim for benefits due to her failure to raise the issue in the proceedings below.

Respondent accordingly requests that this Court deny the Petition for a Writ of Certiorari.

Respectfully submitted,

BRIAN J. SPANO
Counsel of Record
ROTHGERBER JOHNSON & LYONS LLP
1200 Seventeenth Street, Suite 3000
Denver, Colorado 80202
Telephone: (303) 623-9000

GARY NELSON
HEYL, ROYSTER, VOELKER & ALLEN
Suite 600, Bank One Building
124 S.W. Adams Street
Peoria, Illinois 61602
Telephone: (309) 676-0400

Attorneys for Respondent
The Gates Health Care Plan